Community Care Teams:
An Approach to Better Meeting the Needs of Frequent Visitors to the ED

Complex Care Committee

Acknowledgements

Overview

- Definition of a CCT

- Brief Summary of Emergency Department utilization

- CT BHP Frequent Visitor Program

  - Goals

  - Strategy

- Community Care Teams (CCT)

  - What is a CCT?

  - Critical Components

  - Stages of CCT Development

- CCT Webinars Planned for October/November 2015

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CCT Defined

- A team of hospital staff, behavioral health, health, and social service agencies

- Focused on improving outcomes, care experience, and reducing unnecessary Healthcare expenditures

- For a target population of individuals with behavioral health and/or substance abuse diagnoses

- That are Frequent Visitors to the Emergency Department

Key Topics

- Overview of Frequent Visitors in CT

- CT BHP Intervention Summary

- Critical components of a CCT

- Challenges and Solutions for CCT model replication

Background

- Increasing use of the Emergency Department (ED) is a national and international concern.

- In Connecticut, CCTs are showing promise in their ability to impact outcomes for both the individual and the hospital

The Call to Action – National Statistics

Over the past decade, the increase in ED utilization has outpaced the growth of the general population, despite a national decline in the number of ED facilities. [1]

Overuse of the ED is responsible for $38 billion in unnecessary spending every year. [2]

1 out of every 8 visits to the ED in the U.S. is mental health and/or substance use related. [3]

Such BH visits are 2.5 times more likely to result in an inpatient admission. [4]

Frequent visitors to the ED account for about ¼ of all ED visits. [5]

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Utilization of the ED for Behavioral Health in CT

Top 10% of High Utilizers in CT (4+ visits in 12 months) accounted for 39,222 visits in 2013. [6]

Frequent BH Visitors (7+ visits in 6 months) account for 16% of BH ED visits statewide (n = 721) [7]

Individual hospital Frequent Visitor averages ranged from 6% to 33% of their total BH ED visits. [8]

1 in 5 BH ED visitors are homeless compared to 1 in 20 of the general adult Medicaid population. [9]

Above data is for Medicaid Adults 18+ only

Characteristics of Frequent Visitors in CT

Higher rates of housing instability and homelessness

High rates of substance use disorders, particularly alcohol

High rate of medical comorbidities

Most often are already connected with the BH service system

Above data is for Medicaid Adults 18+ only

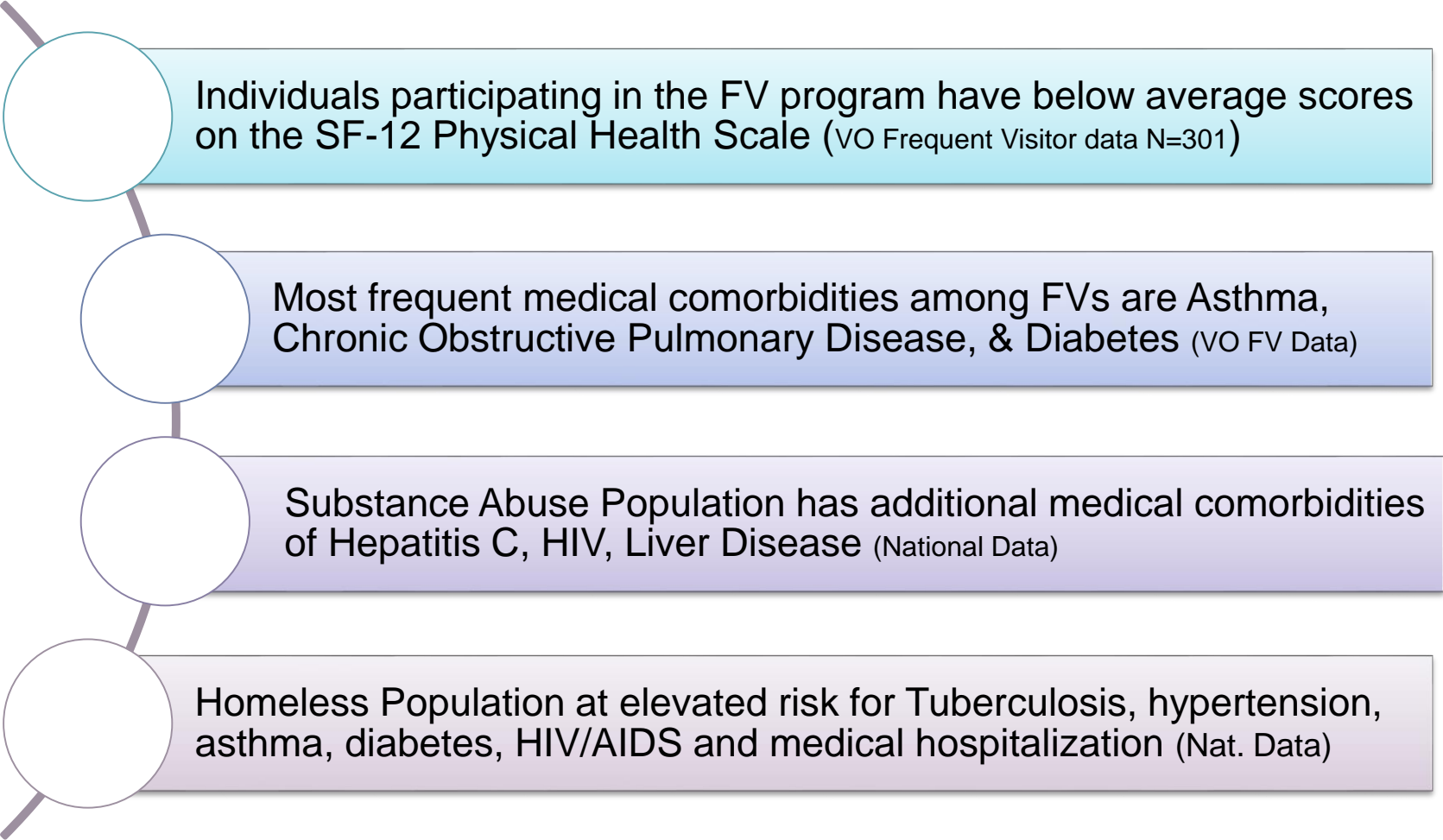# Utilization of the ED for Physical Health in CT

17% of American adults have comorbid mental health and medical conditions. Patients with complex medical and behavioral health needs have a disproportionate impact on ED services.[10, 11]

In 2013, HUSKY Health frequent users accounted for approximately 1.7% of the members with an ED visit but 11.1% of the medical visits to the ED.[12]

Nearly 20% of ED visits in 2013 for Frequent ED Utilizers had a secondary behavioral health or alcohol related diagnosis.[13]

In 2013, of the 4,525 ED High Utilizers 76.7% resided in Fairfield, Hartford or New Haven county.[14]

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BH and Medical Comorbidity Among BH ED FV

Individuals participating in the FV program have below average scores on the SF-12 Physical Health Scale (VO Frequent Visitor data N=301)

Most frequent medical comorbidities among FVs are Asthma, Chronic Obstructive Pulmonary Disease, & Diabetes (VO FV Data)

Substance Abuse Population has additional medical comorbidities of Hepatitis C, HIV, Liver Disease (National Data)

Homeless Population at elevated risk for Tuberculosis, hypertension, asthma, diabetes, HIV/AIDS and medical hospitalization (Nat. Data)

The CT BHP
ED Frequent Visitor Program
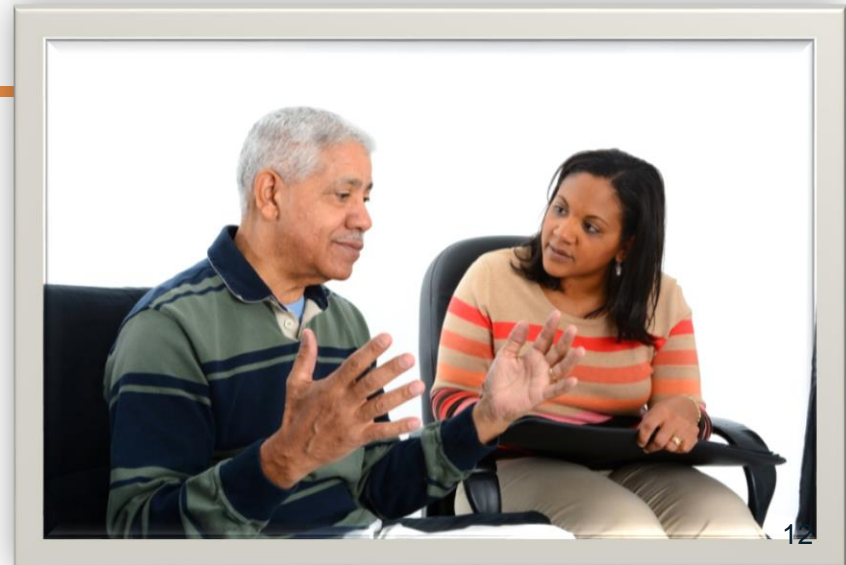
ED Frequent Visitor Intervention Goals

Reduce BH Frequent Visitor overall utilization of the ED

Reduce BH ED Readmission Rates

Improve connections to care following BH ED visit

Additional Objectives

Identify and engage members with high ED utilization and multiple co-morbid conditions, including those with chronic medical and behavioral health or substance abuse conditions to:

- Refer to CHNCT Intensive Care Management to address fragmented care, exacerbations and/or complications of chronic disease and impaired social, economic and material resources.

- Co-manage with CHNCT to incorporate behavioral and medical supportive services.

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Identified Hospitals

Other Hospitals with CCTs

CT BHP Frequent Visitor Program Overview

Target Population
- Top 2% of BH ED Visitors
- 7+ BH ED Visits in 6 months
- BH diagnosis as primary or secondary on claim
- Medicaid Member

Identify Frequent Visitor

Intensive Care Manager/Peer

Community Care Team

Medical and Behavioral Health ASOs partner to co-manage members with chronic conditions
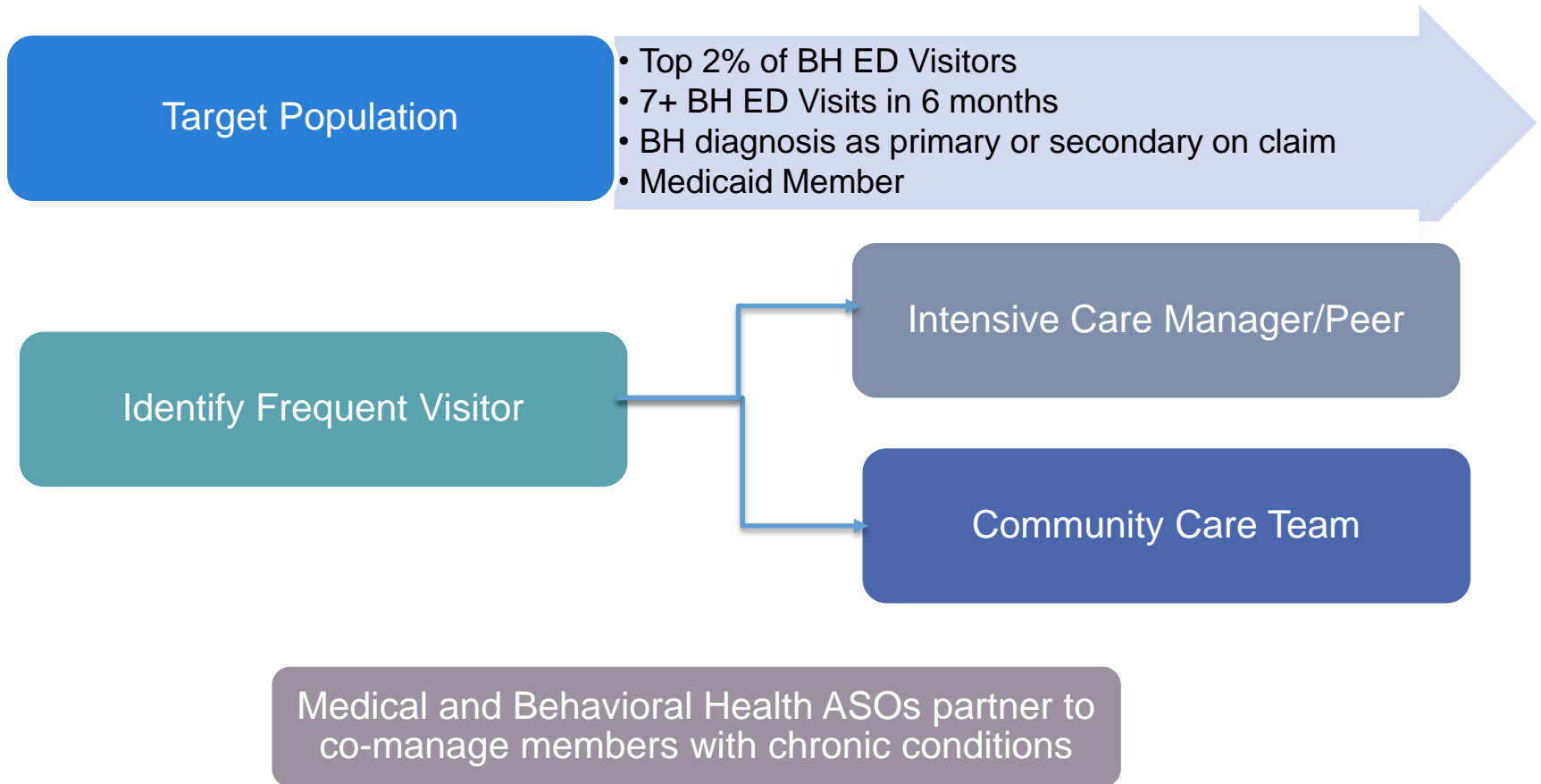
The Community Care Team Approach to Frequent Visitors to the ED

Acknowledgement

The Smarter Choice for Care
MIDDLESEX HOSPITAL
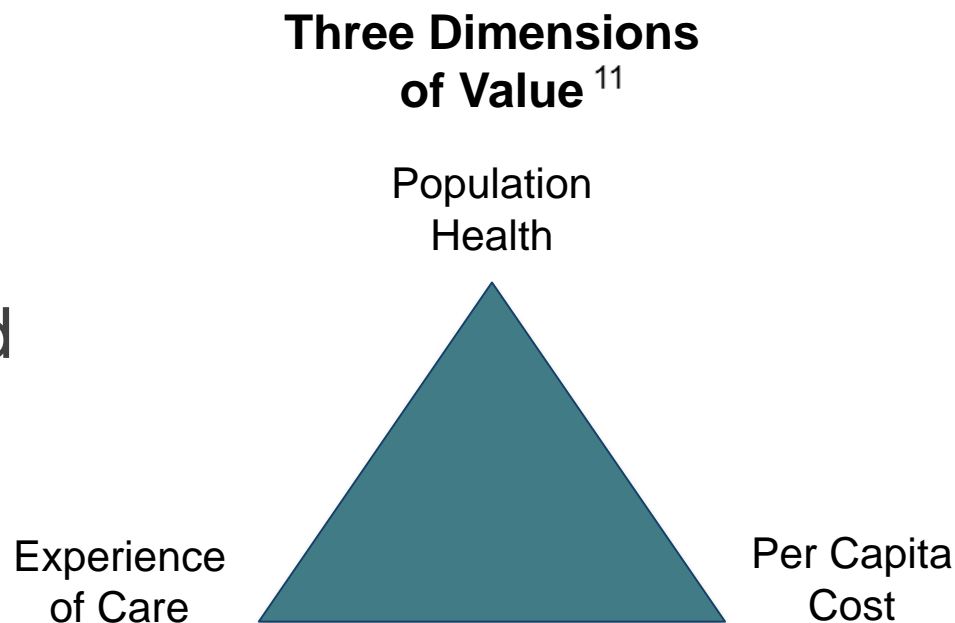
Why a Community Care Team?

- Patient-centered care

- Improved health outcomes

- Community collaboration is required to improve health outcomes

- Potential for cost savings to the community

Three Dimensions of Value [11]

Population Health

Experience of Care

Per Capita Cost

Community Care Teams (CCTs) Strategy

- Multi-agency involvement

- Utilizes a care coordination teaming approach

  - Develop individualized care plans that identify and address basic needs

- Communicate plan with individual to increase likelihood of success

Pro Tip!
Employ a peer professional to connect with member

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Critical CCT Components:
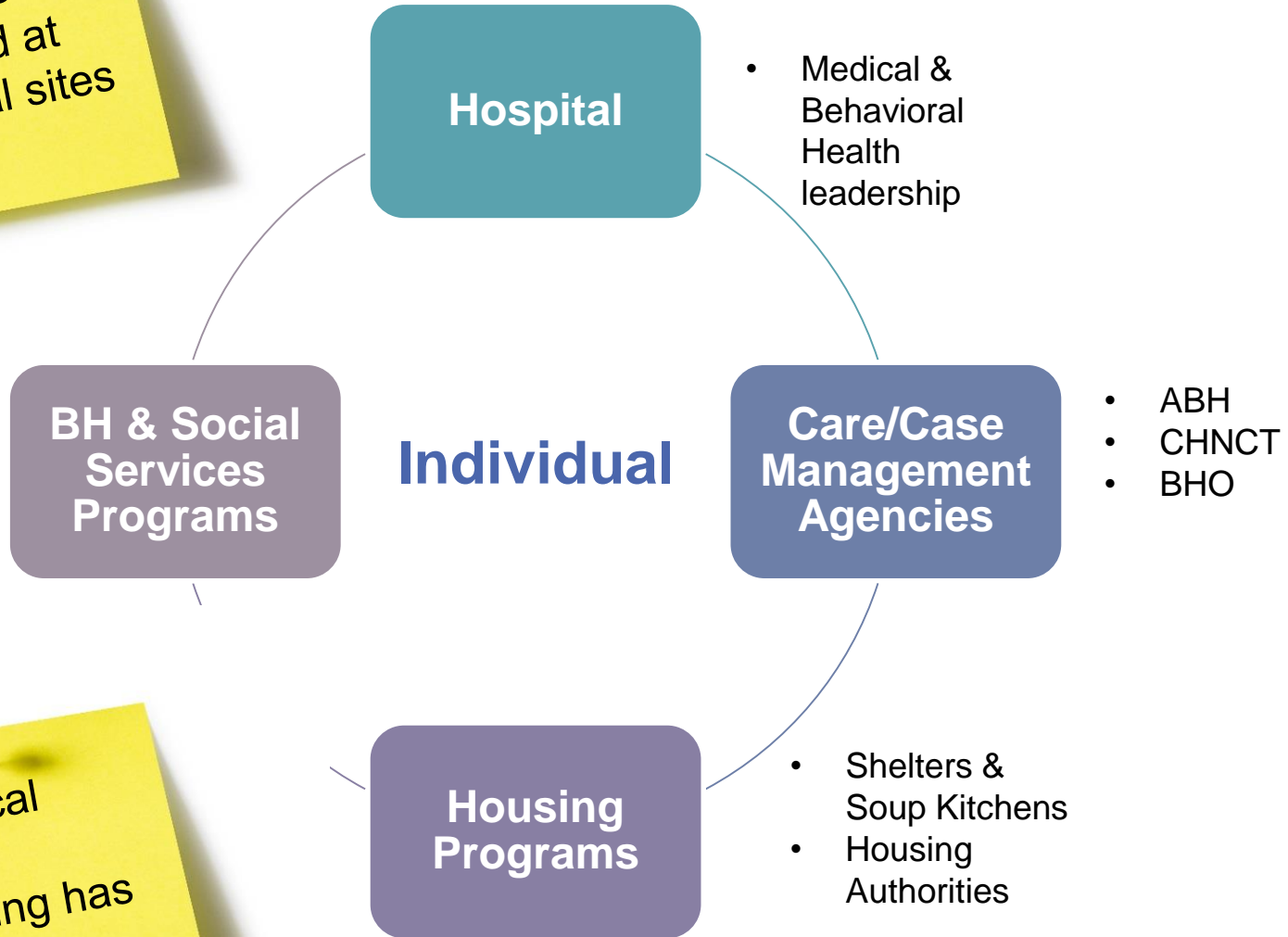## Consistent Commitment

- Commitment across multiple hospital departments, key agencies and support networks

  - Training of staff to recognize care plans

  - Dedicated staff to attend CCT, enter/update care plans

  - IT Modifications

  - Agencies that "step up" to assist

- "Navigator" person

  - Meeting facilitation and prep

  - Maintain ROIs

  - Liaise between CCT, ED and patient

Critical Components cont'd:
CCT Membership
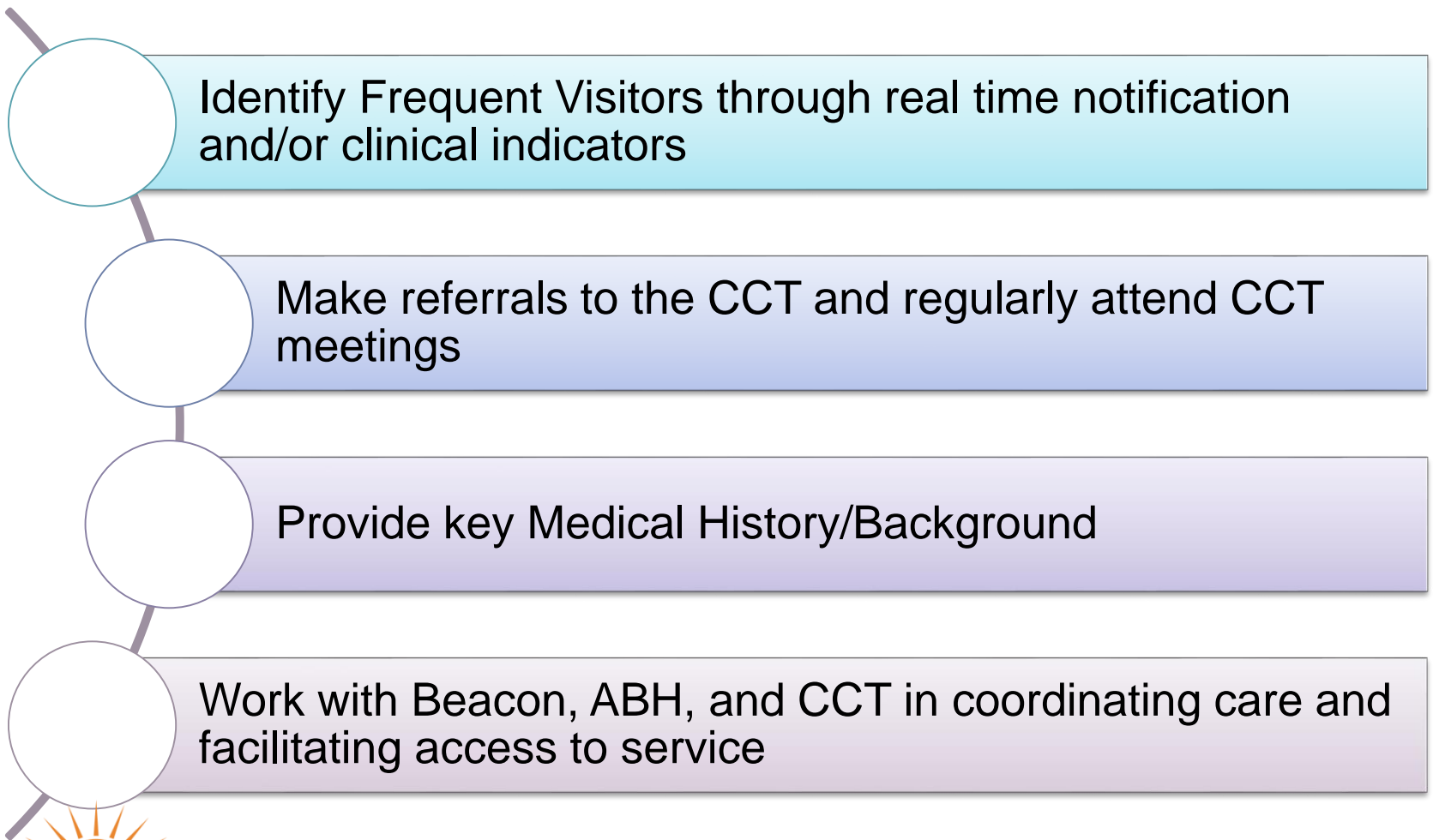
Most CCTs are held at hospital sites

Hospital
- Medical & Behavioral Health leadership

- Outpatient MH/SA
- LMHA
- FQHC
- VNA
- CSSD
- Municipal Agencies

BH & Social Services Programs

Individual

Care/Case Management Agencies
- ABH
- CHNCT
- BHO

A typical CCT meeting has 10-20 participants

Housing Programs
- Shelters & Soup Kitchens
- Housing Authorities

Role of CHN in CCT Process

Identify Frequent Visitors through real time notification and/or clinical indicators

Make referrals to the CCT and regularly attend CCT meetings

Provide key Medical History/Background

Work with Beacon, ABH, and CCT in coordinating care and facilitating access to service
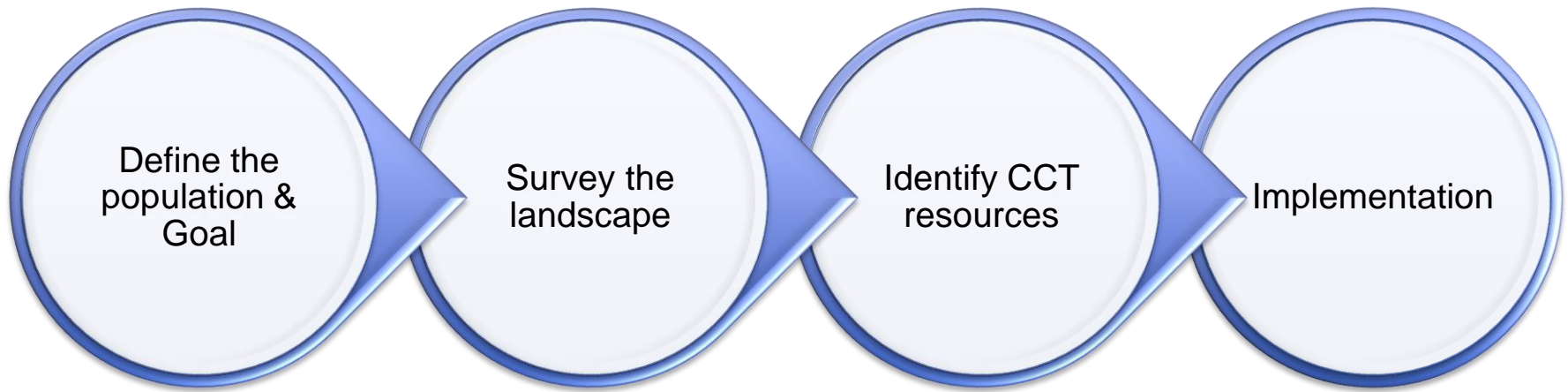
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Critical CCT Components cont'd
Release of Information (ROI)

- CCTs utilize a ROI that lists **all** provider members of the CCT

- The member signs the CCT ROI

- ROIs make the work of the CCT possible

Pro Tip! For CCT member list, more is better!

Stages of CCT Development

Define the population & Goal → Survey the landscape → Identify CCT resources → Implementation

Who?	Existing Processes	Leadership	Execution of Care Plan
What Criteria?	Build new vs. Expand	Logistics, referrals, ROIs, mtg management.	Feedback and Evaluation
How Identified?	What's working?	EHR & Technology	Track Metrics/Outcomes

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CCT Implementation Challenges & Solutions

Challenge	Solution
Personnel and resources to manage the CCT	Use anticipated cost offsets to fund resources, seek external funds
Recruiting and maintaining essential community providers	Carefully select participant based on their contact w/members, make sure meetings are productive, follow-up
Inconsistent commitment to the process by select hospital leadership	Seek buy-in from all parties early on, be persistent and sell based on how it can benefit the ED and the hospital
Hospital and system culture around recovery	Model Recovery Orientation, Engage CCAR, Offer Training
Obtaining approval and consistent use of the ROI	Start Early, use examples from successful projects, connect lawyers to lawyers
EHR limitations or restrictions	Address HIPAA and compliance concerns, point to successful projects
Lack of communication/training around protocol	Integrate Training into Implementation Protocol, Plan for turnover/changes

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Barriers to Care Coordination for Members

Challenge	Solution
Lack of housing – no safe place to go while connecting to care	Housing Agencies/Shelters at the Table, outreach into the community
Medical complexities prohibit access to services	coordination with CHN, engage primary care in CCT
Member choice/readiness	Be patient, respect choices, use MI Techniques
Transportation	Know available resources, purchase vouchers/tokens, seek creative solutions

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CCT Expansion

In addition to the CCTs associated with the CTBHP ED Frequent Visitor program, CHNCT actively participates in the following CCTs:

Norwalk Hospital

Waterbury Hospital

Middlesex Hospital

Stamford Hospital

New Haven Care Coordination Collaborative

CTBHP Case Study

Clinical Summary:

- 53 year old white male Husky C member
- Homeless
- Registered Sex Offender
- Severe ETOH Abuse
- Diabetes, Acute Pancreatitis, Cognitive Impairment
- Schizoaffective
- Traumatic Brain Injury
- 20 Inpatient Detoxes and 20 ED visits in 6 months

CTBHP Case Study
CTBHP ICM/Peer Interventions

- Member Identified after visit to the ED
- Member voluntarily agreed to ICM/Peer Program
- Member agreed to sign CCT ROI
- Collected Opt-in Information regarding SF-12, ICM Acuity Assessment
- Developed a Wellness Recovery Action Plan (WRAP)
- Utilized Motivational Interviewing over multiple visits/phone calls to engage member
- Utilized a Harm reduction approach
- Agreements that reporting to appointments sober would be necessary to secure housing
- Supported goal to achieve own housing despite restrictions associated with the Sex Offender Registry
- Close multi-agency collaboration across housing, medical, behavioral health, etc.
- ICM/peer interventions included:
  - Face to face visits with member
  - Check-in phone calls
  - Care Coordination
  - Care Planning

CTBHP Case Study Outcomes

- Member engaged in SA treatment

- Member reported to treatment sessions sober

- Member cut down drinking over 45 day period

- Member attended primary care appointments

- Member obtained housing

- Member picked up medications daily

- Member achieved sobriety within 60 days of opting in to the program

- Member is working, cooking his own meals, keeps a garden

- Member has been sober over 5.5 months!

CHNCT Case Study

Clinical Summary:

- 53 year old member with history of ETOH abuse, diabetes, hypertension
- 110 ED visits in 2014 to one local hospital
- Member homeless; known to local shelter

Barriers to Care:

- ETOH abuse
- Homeless
- No cell phone
- No medical follow up except ED visits

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CHNCT Case Study
CHNCT ICM Interventions

- Member discussed at local hospital CCT
- Employee from the Residential rehabilitation treatment program attends local CCT meetings
- Member agreeable to treatment for ETOH abuse
- Member was admitted and kept in residential detox program until housing was arranged
- Housing First was able to assist with obtaining an apartment
- Local shelter assisted with food, furniture and household goods
- Member was referred to CHNCT ICM for coordination of care and services
- Member was discharged from residential rehabilitation treatment program but relapsed in 2 days and was allowed to return to residential program for continued treatment
- ICM interventions included:
  - Face to face visit with member
  - Ongoing counseling regarding diabetes and medications
  - Arrange for glucometer and diabetic supplies
  - Assist with obtaining a free cell phone

CHNCT Case Study Outcomes

- Member completed residential treatment program

- Member was discharged to his own apartment

- Member attended an IOP program on discharge

- Member had a part time job at Good Will upon discharge from residential program

- Member attended follow up MD appointments at local Community Health Care Center

- Member is being followed by CHNCT Care Coordinator for continued medical follow up and diabetic testing

- Member has been in housing for 6 months

- Member has not had any ED visits since January 2015

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VO CCT WEBINARS – 2015

Samantha.Forbes@valueoptions.com

Adult CCTs
- **November 17, 2015: 2-3:30pm**
- **November 19, 2015: 11-12:30pm**
- **December 1, 2015: 11-12:30pm**
- **December 4, 2015: 11-12:30 pm**

YOUTH CCTs
- **December 15, 2015 11-12:30**

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Your Questions Answered!

For More Information about CT CCTs…

- Norwalk Hospital Community Relations Weblog Video interview on the Greater Norwalk Community Care Team with Dr. Kathryn Michael retrieved from http://norwalkhospital.org/about-us/community-relations/

- Rigg, M. (June 6, 2015). "'Care Teams' Bring Mental Health Services into Community" Danbury News-Times. Retrieved from http://www.newstimes.com/printpromotion/article/Care-teams-bring-mental-health-services-into-6311463.php

- Middlesex Hospital Website pdf "Middlesex Community Care Team Facts At-A-Glance May 2015. http://cceh.org/wp-content/uploads/2015/06/Middlesex-County-CCT-Fact-Sheet-5_13_15.pdf

- Faust, A. Middlesex United Way Weblog. (March 7, 2013.) "The Community Care Team – Brilliant Idea." Retrieved from http://www.middlesexunitedway.org/blog-entry/07-03-2013/community-care-team-brilliant-idea

- Connecticut Hospital Association Press Release. June 13, 2013. "Middlesex Hospital to Receive the 2013 Connecticut's Hospital Community Service Award." Retrieved from http://www.cthosp.org/CHA/assets/File/newsroom/pr/Community%20Service_Middlesex%20Hospital_.pdf

Thank you

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2. New England Healthcare Insitue March(2010). A Matter of Urgency; Reducing Emergency Department Overuse. NEI Research Brief http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

3. Owens, P., Mutter, M., Stocks, C.(2007) Mental Health and Substance Abuse-Related Emergency Department Visits among Adults. Statistical Brief #92. Agency for Health Care and Research Quality. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf

4. Owens, P., Mutter, M., Stocks, C.(2007) Mental Health and Substance Abuse-Related Emergency Department Visits among Adults. Statistical Brief #92. Agency for Health Care and Research Quality. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf

5. LaCalle & Rabin. (2014). "Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications." From the Department of Emergency Medicine, Mount Sinai School of Medicine, New York, NY.

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7. Adult Frequent Behavioral Health ED Visitors & Hospital Specific Measures" July 2015 CHA Presentation

8. Adult Frequent Behavioral Health ED Visitors & Hospital Specific Measures" July 2015 CHA Presentation

9. Improving Outcomes & Reducing Utilization Through Intensive Care Management, Peer Support & Systems Intervention. (2014). CT Behavioral Health Partnership Performance Target submission.

10. Bringing Behavioral Health into the Care Continuum, American Hospital Association, January (2012). http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf last visited 10/12/2015

11. Crane, S. MD, Collins, L. RN, et al., (2012) "Reducing Utilization by Uninsured Frequent Users of the Emergency Department," Journal of the American Board of Family Medicine, Vol. 25, No. 2, Pp 184-191

12. Reduction of Inappropriate Emergency Department Utilization, June 19 Complex Care Committee Presentation – based on 2013 data

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13. PA 14-62 2013 ED Summary Report submitted March 2015 to the CT Department of Social Services

14. Reduction of Inappropriate Emergency Department Utilization, June 19 Complex Care Committee Presentation – based on 2013 data

15. Mental Health and Chronic Diseases, October (2012), CDC National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. http://www.cdc.gov/nationalhealthyworksite/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf last visited 10/12/2015

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